Montana
2016 Health Insurance Training
Certified Exchange Producers

Christina Goe, General Counsel
October 29, 2015

MONTANA HEALTH INSURANCE ANSWERS
www.montanahealthanswers.com

MONTANA COMMISSIONER of SECURITIES AND INSURANCE
MONICA J. LINDEEN

2015 Enrollment Analysis: Successes

- In May 2015, CSI completed an insurer enrollment survey of the individual and small employer group markets, which produced the following results:
  - Between January 1 and May 1, 2015, enrollment in the individual market grew by 16,384 covered lives, compared to enrollment on December 31, 2014, an increase of 23.3%
  - During the same time period, the small employer group market increased by an estimated 2,739, a decrease of 6.5%
  - The net gain in traditional Medicaid and Healthy Montana Kids (HMK) enrollment during that time period was 4,123

Enrollment Analysis: Successes (cont.)

- CSI estimates that approximately 23,000 previously uncovered individuals gained coverage between January and May 2015. The estimate of uninsured in Montana was 195,000 (approx. 20%) in 2013
- The overall uninsured rate has been reduced to an estimated 15 %
- The number of individuals estimated to be in the "Medicaid gap" is 50,000 to 70,000. Approximately 20,000 of those are American Indians.

Montana Medicaid and Expansion 101

Christie Twardoski , DPHHS, will present on changes in Medicaid coverage.

For more information about the HELP Act go to:

www.dphhs.mt.gov/medicaidexpansion

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Coverage Groups

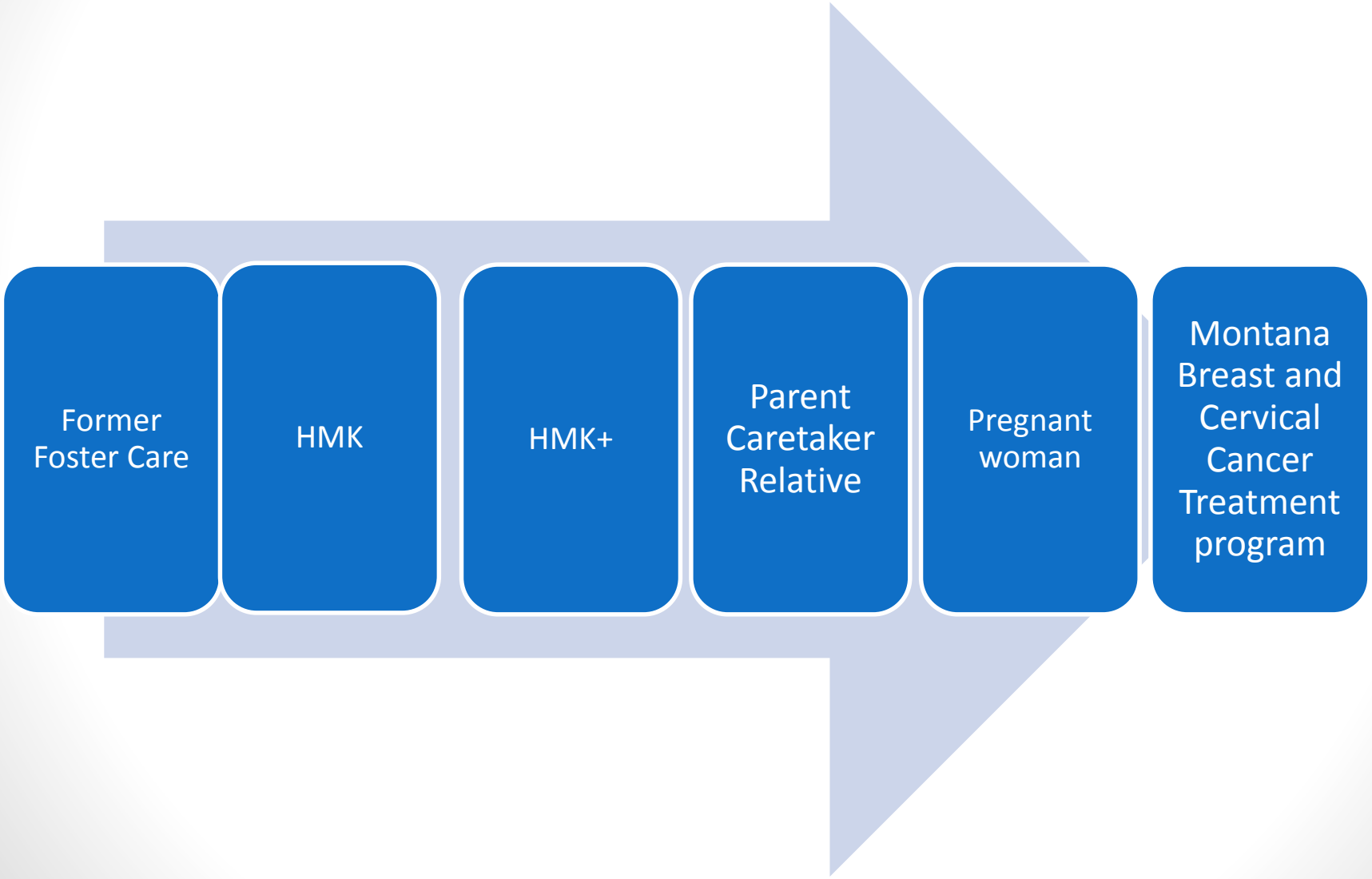
Other Medicaid programs

- Age 65 or older (aged) Blind or disabled according to Social Security criteria
- Women diagnosed with breast or cervical cancer or pre-cancer and receiving treatment
- Medicare Savings Plan coverage that pays Medicare premiums, and may pay co-pays/deductibles
- Medically needy* coverage for children and pregnant women
  - *Medically needy is coverage for individuals whose income exceeds regular program limits

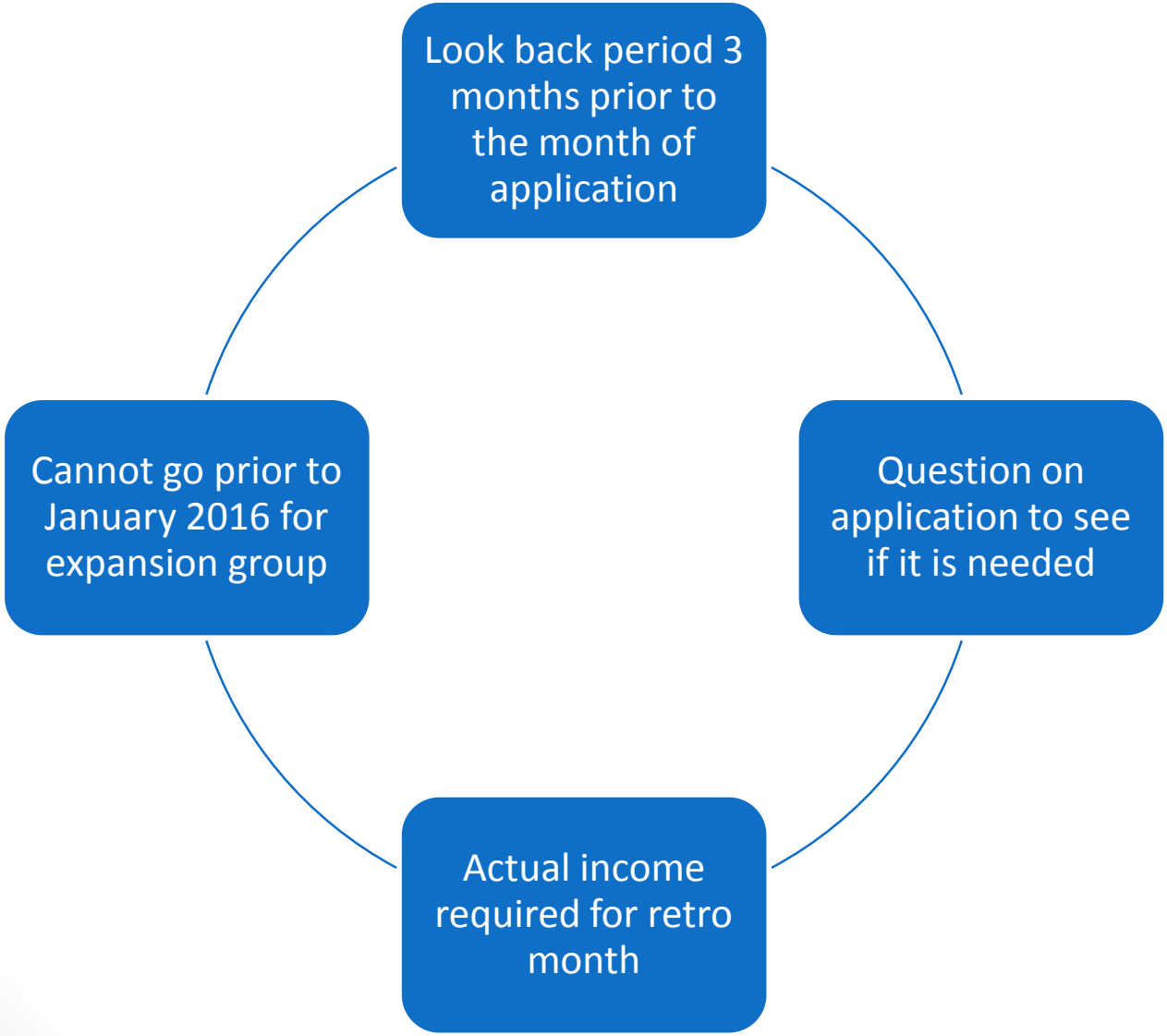
ACA Medicaid programs

- Parents and Caretaker Relatives
- Children age 18 and under
- Pregnant Women
- Former Foster Care children
- HMK (HMK and HMK+)
- ****Expansion*****

Presumptive eligibility



Retroactive Medicaid Coverage

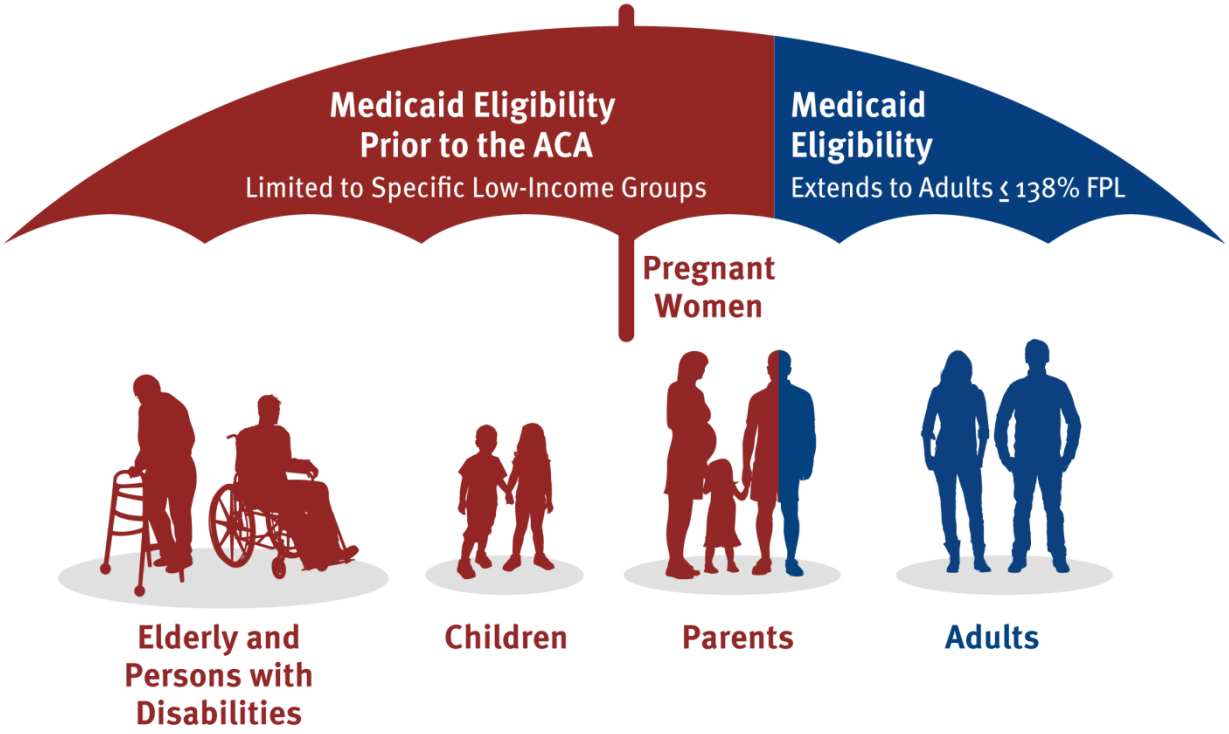


Is there a resource test for ACA programs?

No!

Expansion 101

Medicaid Eligibility



Parents and adults without kids living at home between the ages of 19-64 with an income at or below 138% of the Federal Poverty Level (FPL)

$16,424 for an individual and $27,724 for a family of three in 2015

Covered by the Help Act

Eligible and Services Delivered by Medicaid State Plan

(Subject to Copayment)

ACA Adult Medicaid

- **American Indians/Alaska Natives**;
- **Individuals with exceptional medical needs;**
- Individuals who live in a geographical area with insufficient health care providers;
- Individuals in need of continuity of care that would not be available or cost-effective; and
- Any other individuals exempt by federal law who are aged 19-64 and with incomes up to 138% FPL.

Eligible and Services Delivered by TPA

(Subject to Premiums and Copayment)

ACA Adult

- Other newly eligible adults and parents under 138% FPL, aged 19-64.

Over 100% FPL

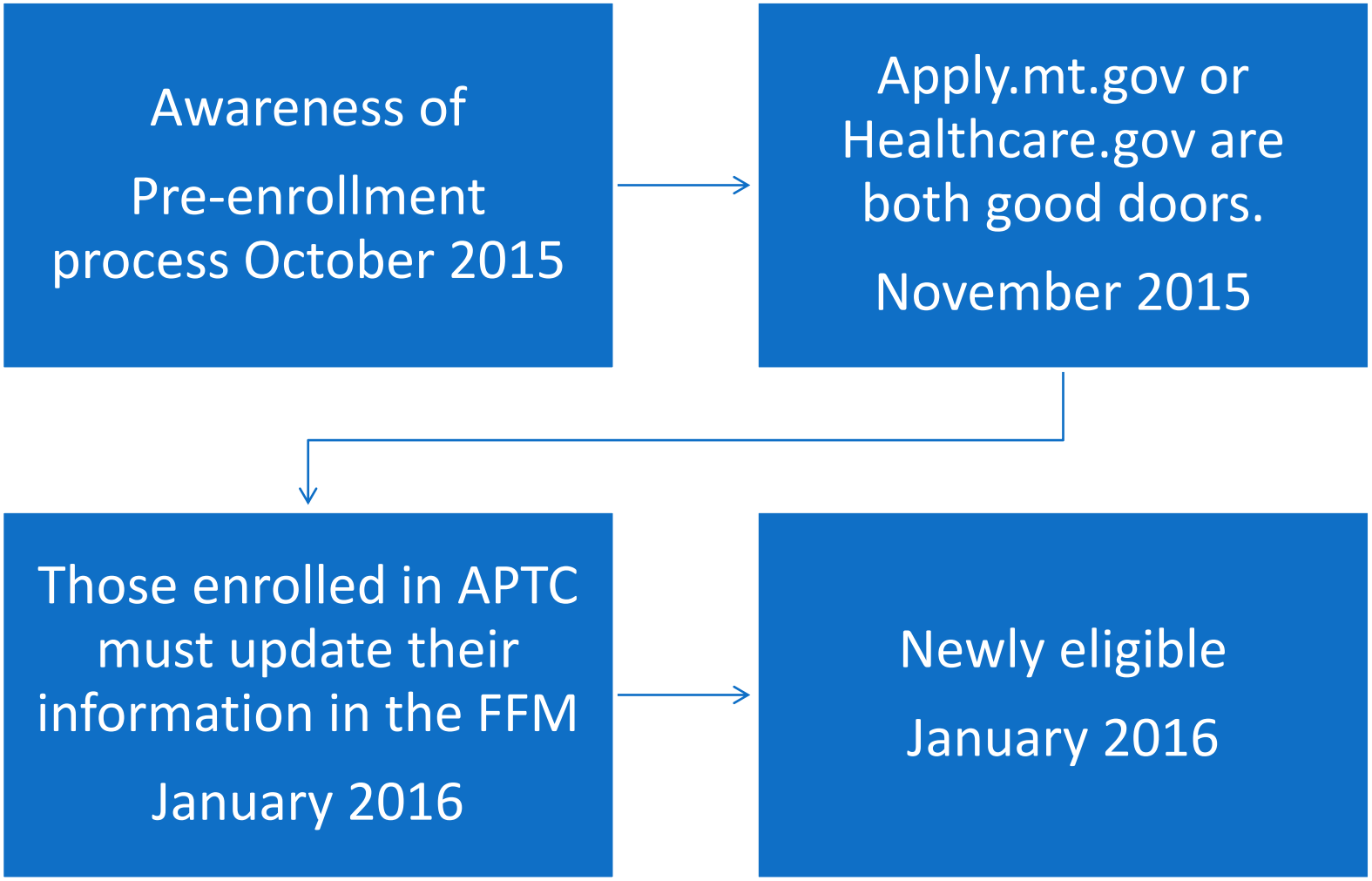
Under 100% FPL

Workforce Assessment, Employment, and Training

Participation in job assessment and planning and wellness can earn exemption from disenrollment for those who earn 100-138% FPL.

All are eligible to participate in employment services assistance including those not subject to disenrollment.

What does this mean for CAC and navigators ?



Health Coverage Options: Pre-enrollment

What is Pre-enrollment?

Pre-enrollment is dependent on approval of the waiver by CMS.

Pre-enrollment will allow individuals to opt-in for coverage in 2016

- Pre-enrollment is allowed and supported by the federal Centers for Medicare and Medicaid (CMS)

A Pre-enrollment Health Coverage Option Notice is scheduled to be sent early October to eligible individuals on giving them the option to opt-in for benefits

Individuals can Pre-enroll by calling
1-844-792-2460 or through apply.mt.gov

After the individual opts-in, the system will automatically set up benefits and notify the individual via the About Your Case/Approval notice

Why Pre-enrollment?

It is allowed under federal law

Streamlined enrollment for eligible individuals, and already verified as eligible based on case and program data

Good news for the client and for staff

- Reduces work burden for staff related to new application processing for adding a program
- Ease of use for client

Pre-enrollment Process

The Pre-enrollment process will contain three parts:

1

Identify individuals and send general notice for enrollment:

Individuals registered in CHIMES who are eligible for Medicaid Expansion benefits will be automatically identified by the system. The system will calculate a premium amount for each of these individuals, and a notice will be automatically sent with the premium amount details and an option to opt-in to receive coverage.

2

Collect Individual responses:

- Individuals can opt-in through apply.mt.gov or by calling # 1-844-792-2460.
- **The responses will be available monthly starting at the end of November.**

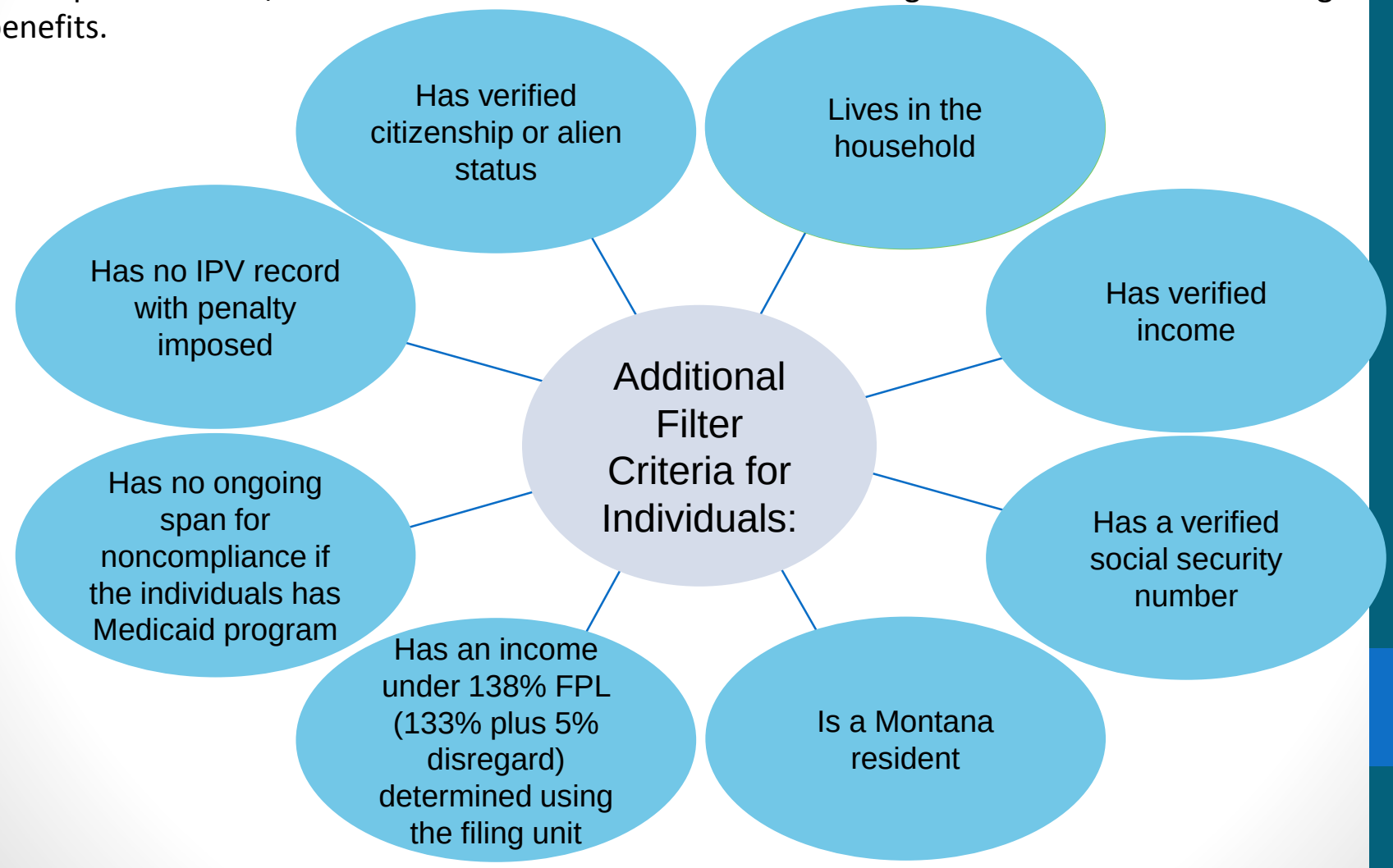
3

Set up benefits for individuals:

Benefits will be automatically processed for individuals who chose to opt-in.

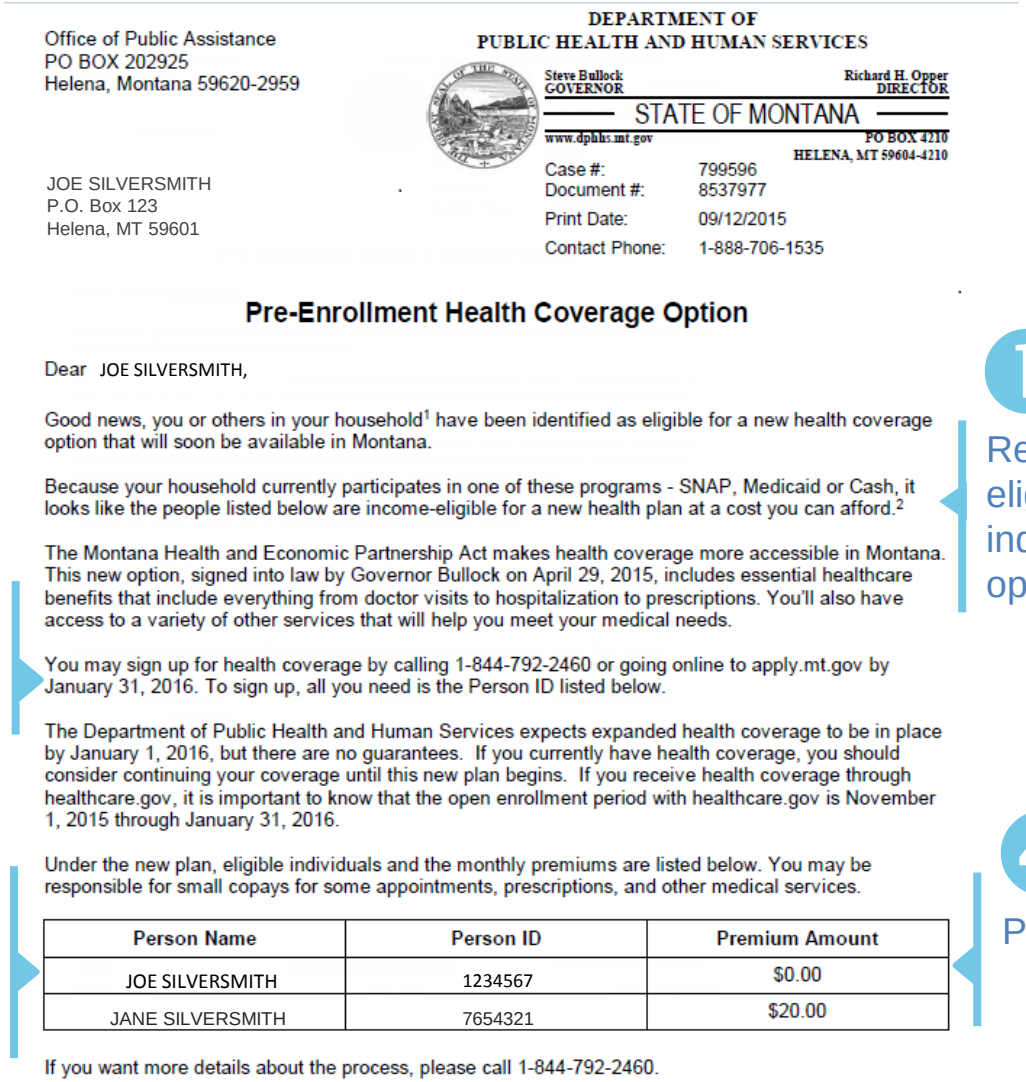
Pre-enrollment Process - Filter Criteria

Individuals will be identified as eligible from existing and verified open SNAP/TANF cases or cases with open Medicaid/HMK that have at least one adult between ages 19-64 who is not receiving benefits.



Pre-enrollment Health Coverage Option Notice

The Pre- enrollment Health Coverage Option Notice will be sent automatically one time per household to the **Primary Individual** through *Correspondence* including the following:



Office of Public Assistance
PO BOX 202925
Helena, Montana 59620-2959

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

Steve Bullock
GOVERNOR

Richard H. Opper
DIRECTOR

STATE OF MONTANA

www.dphhs.mt.gov

PO BOX 4210
HELENA, MT 59604-4210

JOE SILVERSMITH
P.O. Box 123
Helena, MT 59601

Case #: 799596
Document #: 8537977
Print Date: 09/12/2015
Contact Phone: 1-888-706-1535

Pre-Enrollment Health Coverage Option

Dear JOE SILVERSMITH,

Good news, you or others in your household[1] have been identified as eligible for a new health coverage option that will soon be available in Montana.

Because your household currently participates in one of these programs - SNAP, Medicaid or Cash, it looks like the people listed below are income-eligible for a new health plan at a cost you can afford.[2]

The Montana Health and Economic Partnership Act makes health coverage more accessible in Montana. This new option, signed into law by Governor Bullock on April 29, 2015, includes essential healthcare benefits that include everything from doctor visits to hospitalization to prescriptions. You'll also have access to a variety of other services that will help you meet your medical needs.

You may sign up for health coverage by calling 1-844-792-2460 or going online to apply.mt.gov by January 31, 2016. To sign up, all you need is the Person ID listed below.

The Department of Public Health and Human Services expects expanded health coverage to be in place by January 1, 2016, but there are no guarantees. If you currently have health coverage, you should consider continuing your coverage until this new plan begins. If you receive health coverage through healthcare.gov, it is important to know that the open enrollment period with healthcare.gov is November 1, 2015 through January 31, 2016.

Under the new plan, eligible individuals and the monthly premiums are listed below. You may be responsible for small copays for some appointments, prescriptions, and other medical services.

Person Name	Person ID	Premium Amount
JOE SILVERSMITH	1234567	$0.00
JANE SILVERSMITH	7654321	$20.00

If you want more details about the process, please call 1-844-792-2460.

1 Request for eligible individuals to opt-in for benefits

2 Eligible start date

3 List of individuals eligible for Pre-enrollment

4 Premium amount

Timeline

Important next steps:

The Pre-enrollment Health Coverage Option Notice is scheduled to be mailed out early October

Benefits will be automatically set up in CHIMES EA as individuals opt-in

The About Your Case Notice will be automatically sent out after benefits are set up in CHIMES EA

The deadline to opt-in will be January 31, 2016

What do 2016 plans look like?

Look for:

- Prescription drugs cost-sharing
- Provider and mental health office visits-co-payments vs. coinsurance
- What can the consumer afford?
  - The premium is not the only factor
- Maximum out-of-pocket: (in 2016 - $6,850 for an individual and $13,700 for a family) – watch out for HSA compatible (Maximum $6550/$13,100)
- New HMO plans in the market

Glossary of Terms

- **Cost-sharing** – Health care provider charges for which a patient is responsible under the terms of a health plan. Common forms of cost-sharing include *deductibles*, *coinsurance* and *co-payments*. *Balance-billed* charges from *out-of-network physicians* are not considered cost-sharing.
- **Deductible** – A dollar amount that a patient must pay for health care services each year before the insurer will begin paying certain claims under a policy. Some health plans do not apply the deductible to certain kinds of claims, such as provider office visits.

Glossary of Terms

- **Out of pocket maximum** - An annual limitation on all *cost-sharing* for which patients are responsible under a health insurance plan. This limit does not apply to *premiums*, *balance-billed* charges from out of network health care providers or services that are not covered by the plan. The ACA limits the maximum out-of-pocket to $6850 per individual and $13,700 per family in 2016. These amounts are adjusted annually to account for the growth of health insurance *premiums*.
- **Coinsurance** - A percentage of a health care provider's charge for which the patient is financially responsible under the terms of the policy, usually after the deductible is applied.
- **Co-payment** - A flat-dollar amount which a patient must pay when visiting a health care provider, sometimes before the deductible is applied.

Overview of Plan Comparison Chart

- Preventive services –not all are $0
- Emergency Room services—additional cost sharing imposed
  - It is important for consumers to understand what an emergency medical condition is--don't go there unless you are certain.
  - The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. A "prudent layperson" standard is applied.
- All this cost sharing is IN-NETWORK—OUT-OF-NETWORK is often four times higher
  - True emergencies are always treated as "in network."
- Out-of-network cost sharing is "tracked separately." It has a separate and much higher maximum out of pocket. Look to the SBC to see the out-of-network cost sharing.

Plan Comparison Chart (cont.)

- Deductible and usually coinsurance always apply to in-patient services, but also to out-patient surgery, lab and diagnostic tests, emergency room services, some professional services services and sometimes drugs.
- In addition, there are sometimes "special" deductibles and copayments for certain services that insurers want to discourage, such as emergency room. These additional charges can be in addition to the regular deductible and coinsurance.
- However, none of these charges can add up to more than the maximum out-of-pocket.
- **The rate charts for all these plans are on our website at:**

http://montanahealthanswers.com/families/health-insurance-buyers-guide/

PacificSource

- PacificSource has two networks: SmartHealth and PSN. SmartHealth is a more limited network, primarily in Billings and Missoula. The PSN plans offer a broader network.
- PacificSource has two product lines for each network: balance and value.
  - All of the balance plans have pre-deductible, flat dollar copayments for office visits, including mental health, and for all prescription drug tiers.
  - All value plans have all services subject to a deductible before any payments are made by the insurer. However, the maximum out-of-pocket is lower.
    - For instance, you can choose a silver plan with a $3,600 deductible and $3,600 maximum out of pocket.
- Both the SmartHealth and PSN networks have a value and balance option.

Montana Health Coop (MHC)

- Montana Health Coop (MHC) has two networks: Access and Connected Care
- MHC has eliminated all platinum plans and has eliminated all pre-deductible copays for office visits, except in the gold plans.
- Connected Care is the more limited network, mainly in Billings and Missoula
- MHC has three product designs: Access, Connected Care and Connected Care "Plus"
  - Connected care "plus" is a deductible-only plan (including for drugs)—no coinsurance or copayments, but with a lower maximum out of pocket
  - For instance, in the gold connected care "plus" the consumer would pay $2100 deductible before ANY services are covered (except mandated preventative); however, the maximum out-of-pocket is also $2100

**What is a Co-op? - A non-profit health insurer that is member-owned and operated. The ACA created co-ops and provided grants and loans to assist in the establishment to "start up" these new non-profits

Blue Cross Blue Shield of MT (HCSC)

- BCBSMT (HCSC) PPO plans (gold, silver and bronze) and multi-state plans (which are basically the same as the PPO option). BCBSMT has fewer PPO plan offerings in 2016.
  - Pre-deductible copayments have been eliminated, but the plans (except bronze) still include three $0 PCP visits, in addition to the $0 preventive visits
- BCBSMT has added HMO plans in seven counties around Billings Clinic and Missoula Community Medical Center
  - Read these plans carefully to understand the consequences of going out of network
  - These plans include pre-deductible copayments for office visits

Consumer Considerations for Choosing a Plan

- Do I have health issues that may result in significant or frequent claims during the coming year?
- How much cost sharing can I afford?
  - Do I have $6800 in a savings account to cover the cost of higher deductible health plan?
  - Is it better for me to choose a plan with a lower deductible and more up-front costs paid, at least in part?
  - Some plan options have copayments for office visits and drugs that are applied "pre-deductible."
- Check the provider network for each insurer.
  - Are there enough primary care physicians or specialists available in my area? Do they take new patients?
  - Is my doctor in the network?
  - Is my town's hospital in the network?

Considerations when Choosing a Plan (cont.)

- Do I need access to a high cost or specialty tier drugs?
  - Does this plan include that drug in their formulary? What is the cost- sharing for that drug?
- Do I travel out of state a lot or have family members that live out of state?
  - If so, evaluate that plan's "out-of-state" network.

**OUT-OF-NETWORK COST SHARING IS VERY HIGH

- Consumers can link to the insurer's "summary of benefits and costs" (SBC) to obtain more detail about cost-sharing arrangements in each plan.
- In addition, www.montanahealthanswers.com now has a plan cost-sharing comparison chart for all marketplace plans.

Not all Silver Health Plans are Created Equal

- The ACA requires individual and small employer group health plans to be placed in "metal tiers" of the same actuarial value: platinum, gold, silver and bronze.
- However, there are numerous different health plans offered by the same issuer in each metal tier, each with significantly different cost sharing arrangements
  - For instance, deductibles in silver plans range from $2000 to $4100
- Higher deductibles may be combined with much lower other types of cost sharing, such as coinsurance and copayments
  - For some benefits, consumers pay only "pre-deductible" flat dollar copayments, i.e. out-patient

Silver Plans (cont.)

- Sometimes co-payments are "pre-deductible"—but often they are not
- Consumers should evaluate all cost-sharing options carefully, so they understand how the plan works before they purchase it
- Consumers must be reminded to stay "in-network"
- The "Summary of Benefits and Coverage" can help with that understanding
- The "same" actuarial value does not mean standardized cost-sharing parameters

Always Look at the Drug Plan

- Does the consumer know they need a lot drugs, or in particular high cost drugs?
  - Can they afford to pay the entire deductible before receiving any help paying for their drugs?
- Every insurer in the silver tier and above has at least one plan option that has "pre-deductible" copayments in the drug plan.
- All insurers are using pharmacy networks now**—check the network!**
- There is always an "exception" process, in addition to regular internal and external appeal.
  - May be expedited
- All drug plans are "managed" with tools such as "step therapy" and "tiering."
  - Drug plans described on Montanahealthanswers.com

Glossary of Terms

- **Generic drugs** - the least expensive under a drug plan—a drug where the patent has expired and it is no longer only available as "brand name." These are "tier one" drugs.
- **Preferred drug** - A drug formulary is a continually updated list of medications supported by current evidence-based medicine that encourages the use of safe, effective medications. Insurers often use the term "preferred drug" in their drug plans for these "brand name" drugs that are placed in "tier two" usually.
- Formulary development also includes elements of affordability—the most cost effective or lower priced drugs. Different brand name drugs may do the same thing, but the pricing on one is better than another. Formularies are updated quarterly—and changes are often driven by cost.
- **Non-preferred or non-formulary -** also brand name drugs - usually those that are more expensive than the preferred option, but treat the same illness or symptoms. Sometimes these drugs are also considered less effective or less safe.

Glossary of Terms (cont.)

  - Physicians may justify access to non-formulary drugs when medically necessary.
  - Every drug plan has an "exception" process that allows the physician and the insured to approve the use of a different drug, but at the lower tier cost sharing.

- **Specialty Tier drugs** - Non-generic, brand name drugs that are used to treat complex or chronic conditions that usually require close monitoring, such as MS, hepatitis, rheumatoid arthritis, cancer and others. These drugs may require special handling and may need to be dispensed through a specialty pharmacy. These drugs are very expensive—often thousands of dollars for a 30 day supply. ($600 to $10,000+ for a 30 day supply)
- Insurers usually require prior authorization for these drugs.
- If authorization is denied, there is an exception process, followed by the normal internal and external appeal process.

Network Adequacy

- A new network adequacy law in Montana was effective October 1, 2013 for PPO plans. Most "network-type" health insurance plans, including dental and vision, sold in Montana are "PPO" plans.
- In May 2015, the CSI implemented new network adequacy administrative rules that further clarify how a network is determined "adequate."
  - An adequate choice of necessary provider types, including mental health and pharmacies;
  - Provider to covered person ratios; available specialists; geographic accessibility; wait times for appointments
  - If a specialist is not available to provide medically necessary care, the insurer must pay as if the service were provided "in-network"

Network Adequacy (cont.)

- The rules require the provider directory to be searchable, accurate and updated monthly. Networks for different plans must be clearly designated.
- Consumers must be notified when a provider that they have accessed leaves the network.
- **Continuity of Care:** If a doctor leaves the network during the plan year, and if the consumer is in an "active course of treatment" for a serious disease or a pregnancy, the treating physician may seek to finish the course of treatment under the original contract terms of the provider contract, pursuant to the provisions of the administrative rule

Network Adequacy Terms

- **Balance billing** - When you receive services from a health care provider that does not participate in your insurer's network, the health care provider is not obligated to accept the insurer's payment as payment in full and may bill you for unpaid amount. This is known as “balance billing.”
- **Out-of-network provider** - A health care provider (such as a hospital or doctor) that is not contracted to be part of a managed care organization’s network (such as an HMO or PPO). The covered person will be required to pay a higher portion of the total costs (often 4 times higher) when he/she seeks care from an out-of-network provider (except for emergency services); plus they will pay the balance billing.

Mental Health and Chemical Dependency

Individual and small group health insurance must include coverage for mental health and chemical dependency services:

- Behavioral health treatment, such as psychotherapy and counseling;
- Mental and behavioral health inpatient services; and
- Substance use disorder treatment.

- The dollar limits in the Montana insurance code for mental health and chemical dependency are preempted by operation of federal law

Mental Health Parity and Addiction Equity Act

- The Mental Health Parity and Addiction Equity Act of 2008 requires health insurance companies to cover mental health the same as physical health
- Health insurance companies cannot place more restrictions on mental health treatment or addiction disorder benefits than the restrictions they apply to physical illness, generally
    - Also, cost-sharing cannot be higher; co payments and coinsurance must be the same as for physical illness
- Costs for mental health care can't have a separate deductible
- This law originally only applied to large employer group health plans. However, The ACA expanded this law to all individual and small group employer health plans beginning on January 1, 2014.

Mental Health Parity (cont.)

- Consumers need to understand their rights in this area
  - The law is still new and claims are not always processed correctly
  - A visit to a counselor, such as an LCSW or LCPC or psychologist is generally the equivalent of an "provider visit" such as a physician, PA or APRN and the same cost sharing should apply; i.e. a co-payment. Also the same types of preauthorization

Insurers may not apply additional scrutiny to the payment of mental health claims. This is known as a "non-quantitative treatment limitation." For instance, insurers may not:

  - Require that every type of mental health out patient treatment be "pre-authorized;" or
  - Require that treatment providers provide an excessive amount of justification for ongoing treatment such as out patient therapy

Habilitative Services

The following definitions are now found in all Montana health insurance policies:

Habilitative:

Coverage will be provided for habilitative care services when the covered person requires help to keep, learn or improve skills and functioning for daily living. These services include, but are not limited to: (1) physical and occupational therapy; (2) speech-language pathology; and (3) other services for people with disabilities. These services may be provided in a variety of inpatient and/or outpatient settings as prescribed by a Physician.

Rebabilitative:

Coverage will be provided for rehabilitative care services when the covered person needs help to keep, get back or improve skills and functioning for daily living that have been lost or impaired because a the Covered Person was sick, hurt or disabled. These services will include, but are not limited to: (1) physical and occupational therapy; (2) speech-language pathology; and (3) psychiatric rehabilitation. These services may be provided in a variety of Inpatient and/or Outpatient settings as prescribed by a Physician.

Habilitative Services (cont.)

- **Autism—**State mandate specifically includes "applied behavior analysis" treatment for children up age 18. [Mont. Code Ann. 33-22-515]

- **Downs Syndrome:** New in 2016, also includes speech therapy, occupational therapy, physical therapy and "intensive behavioral intervention" for covered children up to age 18. [Mont. Code Ann. 33-22-139]
  - Prescribes visit limits "up to" a certain number—52 or 104.

Pediatric Dental Benefits

- Dental and vision benefits for children under age 19 are a required part of the essential health benefit package
  - These benefits must be the same as those offered in the federal employee plan
- Lifetime and annual dollar limits cannot be applied to pediatric dental and vision benefits
  - A maximum out-of-pocket is established each year
- No individual health plans sold inside the Montana Marketplace offer embedded pediatric dental benefits—all are "9 ½ plans."
  - A "stand-alone" pediatric dental plan must be sold with the 9 ½ health plan in order to make the package complete
  - These plans are known as a certified stand-alone qualified dental plans (QDP)
  - Some small employer group plans now have imbedded pediatric dental

Pediatric Dental Benefits

- There are numerous stand-alone dental plan options offered in the marketplace. Sometimes those plans are combined with adult dental coverage, which are allowed to have annual dollar limits.
- Pediatric dental must have a "high" (85 %) or "low" (70 %) actuarial value and offer a maximum out-of-pocket of $350/one child and $ 700/two or more children.
- Pediatric dental rates may be "underwritten," which means that sometimes the rate shown is "guaranteed" (not subject to underwriting) and sometimes the rate is subject to change (underwritten)—the rate may go up after the application is evaluated by the QDP.

Stand Alone Qualified Dental Plans (QDPs)

- Stand alone qualified dental plans (QDPs) may also be sold **"off exchange"**
  - "Off-exchange" QDPs must seek "reasonable assurance"
- The insurer must obtain "reasonable assurance" that the consumer will purchase a QDP before selling a health plan that does not contain pediatric dental
- This is an issue mostly for insurers
  - Consumers cannot be penalized for not buying it
  - Insurers can be penalized for not obtaining reasonable assurance
- In Montana, insurers are not allowed to "auto-enroll" anyone without their permission into a QDP
  - SEE THE COMMISSIONER'S BULLETIN (dated 11/13/2013) on this issue at: http://csimt.gov/laws-rules/advisory-memos/

Stand Alone QDPs (cont.)

- None of QDPs sold in Montana have an "adequate" network
- The CSI has allowed two dental insurers to have a small cost-sharing differential between "in-network" and out-of-network services
- Consumers should be prepared to pay the out-of-network cost, because very few dentists will sign network contracts

Student Health Insurance

- **Student health plan coverage is considered "individual" coverage,** except that the rates are different than the rest of the individual market AND enrollment in the health plan is contingent upon maintaining student status.
- An offer of student health plan coverage is NOT a barrier to receiving tax credits on the exchange.
  - All university students have access to a student plan—in fact, the terms of their enrollment requires them to have coverage.
- Exchange coverage may be cheaper than student plan coverage (which currently is at a "gold plan" level), especially for students under age 21; or
  - If the student has income amounting 138% or more of FPL; or
  - If the individual prefers less generous coverage—bronze or even catastrophic coverage.
- Some students may be eligible for Medicaid expansion coverage.

Retiree Health Insurance

- Individuals who have retired before the age of 65 do not have to accept their retiree coverage and may enroll in the Marketplace, and also receive tax credits, if eligible
- For instance, the state of Montana retiree coverage is quite expensive and those retirees may consider Marketplace coverage
  - BUT the Marketplace coverage is different and may be less generous
  - State retirees have a one-year period that will allow them to "go back" to the state plan—after that they may not return, even after they turn 65
- The decision to switch can be complicated and involves financial decisions that may require advice from a licensed professional

Over 65-year-olds

- Who are Medicare eligible may not enroll in individual Marketplace coverage
- Refer them to an insurance agent or SHIP counselor
- Depending on the plan type chosen, Medicare supplement insurance may provide lower cost-sharing than Medicare Advantage plans, BUT Medicare supplement is NOT guaranteed issue, except during the 6 month period after turning 65 (there are a few exceptions)
- Medicare Advantage has an open enrollment period every year: Oct. 15 to Dec. 7

Incarceration and Health Insurance

- If a person is "incarcerated," he or she cannot buy private insurance, on the marketplace or otherwise.
  - Incarceration means serving a term in prison or jail; or in Montana, a pre-release center.
  - It does not mean probation, parole or in jail pending trial—not yet convicted.

- Upon release, the person becomes eligible for coverage and will have an SEP—60 days
- No individual penalty can be assessed during the period of incarceration
- When a person has been charged with a crime, but not convicted they may:
  - access the marketplace and keep individual coverage
  - be eligible for Medicaid

ACA Provisions for American Indians & Alaska Natives

The ACA includes provisions relevant to American Indians and Alaska Natives (AI/ANs) who are enrolled members of federally recognized tribes and who purchase coverage in the Marketplace, including:

- AI/ANs with household incomes below 300 percent of the federal poverty level who are enrolled in a Qualified Health Plan (QHP) offered through the individual Marketplace will not have to pay any cost-sharing;
- AI/ANS who qualify for $0 cost-sharing may seek healthcare services anywhere. They do not need referrals from IHS

American Indians & Alaska Natives (cont.)

- The Marketplace will provide special monthly enrollment periods for AI/ANS who are enrolled tribal members; and
- All Indians who are eligible for IHS are exempt from the individual responsibility penalty
- Indian tribes, tribal organizations, and urban Indian organizations are allowed to pay the QHP premiums for qualified individuals, subject to terms and conditions set by the Marketplace.

Definition of Indian

- In relation to special monthly enrollment periods and $0 cost-sharing, Indians must show proof of tribal membership
- That proof will consist of uploading, scanning or mailing a tribal membership card, or other electronic means to prove membership
- The exemption from the individual responsibility requirement does not require tribal membership—anyone who qualifies for Indian Health Services is exempt; but they must obtain and exemption letter for IHS.

Verification of Tribal Membership

- Only enrolled members of federally recognized tribes can receive the benefit of $0 cost-sharing and monthly enrollment periods
- Proof of tribal membership must be received by the Marketplace within 90 days of insurance taking effect
  - Upload a tribal membership card
  - Mail copy of the membership card
  - Electronic tribal membership lists
- Healthcare.gov will only accept uploads as PDFs, not JPEGs
- **Most smart phones save images as JPEGs**
  (If you use a smartphone to obtain a digital copy of your tribal membership card, you will need to convert it to a PDF)

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Renewal Notices

- Scrutinize renewal notices because there are many significant benefit changes, and large rate increases.
- Some of these notices advise of "product withdrawal."
- Existing plans (or a substitute plan) will be "auto-renewed" if the covered person takes no action and their tax credits will be continued at the same level—until the IRS updates its information.
  - If a product withdrawal, a substantially similar plan will be chosen by the issuer to replace the old plan.
- Tell individuals who did not buy plans in the Marketplace last year that they may be eligible for tax credits if they go to healthcare.gov.

***IMPORTANT: If an individual changes their health plan choice, they should notify their insurer, even though the Marketplace is supposed to do that

Update Information

- Consumers need to update their financial information on the Marketplace website even if they want to keep their current plan; this is one of the best ways to ensure that Medicaid expansion eligibility has been determined
- Tax credit amounts are based on the cost of the 2nd lowest silver plan – the price of that plan in 2016 is higher than it was for 2015 – therefore, tax credits will go up
- Insureds will receive renewal notices from companies around November 1, including specific instructions on what to do if they want to keep their plan or change plans
- Some will receive notices that say the plan is no longer offered and they will be enrolled in another "similar" plan. Many times the benefits are significantly different.

Problems with Documentation Verification Regarding Income or Citizenship Status

- Coverage may be terminated if citizenship documentation is not submitted or is inadequate
- Income documentation issues could result in loss of tax credits **but may not result in loss of coverage; the FFM may not terminate coverage for this reason either!**
- Insurers in Montana still have a duty to provide adequate notice of termination or a change in premium.
- **Report problems to the CSI**

The SHOP and Employer Responsibilities

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PACE ACT

- On October 7, 2015, the Protecting Affordable Coverage for Employees Act (PACE) was enacted.
- It amends the definition of small employer by deleting and replacing the section the of the ACA that would have changed the definition to 100 eligible employees in 2016.
  - The federal law now defines small group as 1 to 50.
- States can change the definition to include 100 employees.
  - The state legislature would make that change.
- Currently state law says 2 to 50. By operation of federal law, the definition in Montana is now **1 to 50.**
  - "1" means a small group policy must be issued if the employer has one unrelated employee.
  - Federal counting methods apply

SHOP Marketplace

- The Small Business Health Options Program (SHOP) is open to small businesses with up to 50 employees, or 50 full-time equivalent employees
- The SHOP FTE calculator for a quick way to determine eligibility for the SHOP Marketplace
- For 2015 and 2016 health plans, the SHOP online marketplace is open and enrollment can occur at any time.
  - The online function will provide an opportunity to locate an agent that can manage the small business's account online.
- MHC, PacificSource and BCBSMT all sell plans on the SHOP.
  - Employers may enroll directly through those insurers as well.

SHOP Marketplace (cont.)

- If a small employer has fewer than 25 employees, they may qualify for a small business health care tax credit worth up to 50% of your premium costs
  - Use the SHOP Tax Credit Estimator
- Employers can still deduct from their taxes the rest of the premium costs not covered by the tax credit
- Small businesses can receive tax credits for two years
  - Up to 50% of an employer's contribution to employee plan (35% for tax exempt small businesses)
- Tax credits are only available if employers purchase through the SHOP
- The "employee choice" option is available
- Employees must be unrelated to the owner

SHOP Marketplace (cont.)

Benefits

- The small employer controls the amount of coverage (metal tier) and the amount paid toward premiums; although the SHOP has minimum contribution requirements
- Small employer can choose from 4 levels of coverage (metal tiers) to find a plan that meets the needs of the business and its employees
- Small employers may start coverage any time - Enroll by the 15th of the month and coverage begins on the 1st of the following month
- No "open enrollment period" restriction

All Employer Requirements

- New Disclosure Requirements
  - Notice Regarding the Availability of Marketplace
    - Distribute Model Notices to employees
    - By October 1, 2013 or within 14 days of hire
  - Summary of Benefits & Coverage
    - Effective first renewal following September 23, 2012
    - The insurance company will provide the SBC

All Employer Requirements

- Waiting period for coverage cannot exceed 90 days
  - Seasonal (less than 6 months) and Part Time (less than 30 hours) employees may be excluded
  - Effective first renewal following January 1, 2014
- Fully-insured medical plans prohibited from discriminating in favor of highly compensated individuals

Small Employer Regulations

- Small employers are not required to provide coverage for employees under the ACA employer responsibility requirements
  - Requirement to offer coverage applies only to employers with 50 or more employees or full-time equivalent employees
- Ability to access tax credits through SHOP program
- Even small employer coverage decisions are complex and best served by a licensed insurance agent
  - Tax consequences also must be taken into account, along with decisions about cafeteria plans and HSAs

Determining Employer Status

- Large Employer – any employer who employs an average of at least 50 full-time or full-time equivalent employees
  - Full time – employees who average at least 30 hrs/week (130/mo)
  - Convert all other employees to Full Time Equivalents (FTE) – Take the total number of hours worked by non-Full Time employees and divide by120 hours per month
  - Combine the Full Time Employee count with the FTE count. If this number is at least 50, employer is regulated as a Large Group
  - Exemption for "Seasonal Worker" whose customary annual employment is 6 months or less
  - Employers that qualify as related entities need to combine employee counting and treat as a single employer
- Based upon employment from the previous year

Large Employer Potential Penalties

- Subject to penalty if they do not offer coverage and even one full-time employee obtains coverage through the marketplace and receives a tax credit
- Penalty for an employer who does not offer coverage will be $2,000 per year times the number of FTEs minus 30
- Penalty waives first 30 employers
- **No penalties will be assessed for 2014 but will start with the 2015 tax year, unless the employer has 100 or fewer employees**

Large Employer Potential Penalties

- Employers who offer unaffordable coverage will receive a penalty of $3,000 per year for each employee that receives a tax credit through the marketplace
- Total penalty is limited to the number of FTEs minus 30, multiplied by $2,000
- **The penalty does not apply to small employers with less than 50 FTE. Small employers do not have to offer coverage to their employees.**

Marketplace Certification

- The insurance code has state specific training and certification requirements
- Navigator and CAC Certification page on our website
  - http://www.csi.mt.gov/industry/Navigator_CAC_certification.asp
- Certification is dependent on employment by a CAC Organization or a Navigator grant recipient

Montana Code Annotated
Key Provisions for CEPs

- 33-17-243: A licensed health insurance producer may not sell insurance through the federal Marketplace without first completing BOTH the state and federal training and certification process for certified exchange producers (CEPs)
- 33-17-244: The list of CEPs is maintained by the Federal Marketplace AND the Montana Insurance Commissioner's office
  - The CSI directs all consumers to the directory of CEPs featured on our website at http://montanahealthanswers.com/talk-to-a-human/
  - The Montana list includes those who have completed **both** the state and federal training and certification requirements

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Key Provisions (cont.)

- 33-17-231: An insurer that offers qualified health plans (QHPs) on the Marketplace shall appoint any producer who is certified by the commissioner and follows the appointment application process required by the insurer
  - The insurer cannot place unreasonable requirements on a producer during the appointment application process

CEPs were given this accommodation in the appointment law to allow them the ability to always serve the best interests of the consumer

- All of the health plans present distinctly different cost-sharing arrangements, networks and rates. In the future, that variability is likely to increase
- CEPs have a responsibility to review all of the plan options that are available to ensure that every consumer's needs are met
- Limiting yourself to one or two insurers will inhibit choice for the consumer

Fixed Indemnity Insurance

Any fixed indemnity plan sold in the individual market with a plan year **beginning on or after January 1, 2015** must meet the following criteria:

1. The benefits are provided only to individuals who have other health coverage that is minimum essential coverage within the meaning of section 5000A (f) of the Code;
2. There is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage;
3. The benefits are paid in a fixed dollar amount per day of hospitalization or illness or per service (for example, $100/day or $50/visit) regardless of the amount of expenses incurred and without regard to the amount of benefits provided with respect to the event or service under any other health coverage; and
4. A notice is displayed prominently in the plan materials in at least 14 point type that has the following language:

"THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES."

Fixed Indemnity (cont.)

Consumers who purchase fixed indemnity insurance must attest that they already have MEC.

- The attestation does not have to renewed every year—it only has to occur once
- This attestation must be included in the application materials
- The attestation requirement for "in-force" policies must be implemented by October 1, 2016, if those policies require a renewal application.
- For existing coverage that is guaranteed renewable, a notice must be sent but attestation is not required.
- Refer to the Advisory Memorandum (dated 10/20/2015) on the CSI website at:
  - http://csimt.gov/laws-rules/advisory-memos/

Other excepted benefits and Short Term Health Insurance

- Even though the notices and attestations only apply to certain types of fixed indemnity products, none of the excepted benefit policies (even when bundled) are minimum essential coverage that satisfy the individual responsibility mandate.
- **SHORT TERM HEALTH INSURANCE IS NOT MEC**
  - **Does not satisfy the individual responsibility requirement**
- Representing or allowing customers to assume that this type of coverage satisfies the mandate will lead to penalties for them and you.

Questions?

1-800-332-6148

www.csimt.gov

www.MontanaHealthAnswers.com

For general questions: csi@mt.gov

For licensing questions: producerlicensing@mt.gov

Commissioner Monica J. Lindeen

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